or no") is subject to a whole series of interpretations. Obviously other questions were asked because right at the end of the discussion section it is revealed that some patients were taking laxatives, others analgesics, and so on. But where did this information come from and what is it worth? This is not an idle query on my part because Dr Harris demonstrated no less than 11·7 per cent regular self-medicators, which is an immensely high figure bearing in mind the fact that they are asked if they self-medicate *on most days.*

The second point concerns the presentation of the data. Tables 4, 8, 9 and 10 all quote a chi-squared value which is simply not acceptable. The chi-squared technique is not terribly accurate for small samples and it is contraindicated when any of the cells of the table have less than three in them. Not only do the authors not appear to know this, which is startling given that two of them are academics, but they make the classical error of misinterpreting the useless chi-squared value in Table 8 by saying that "the suggestion of significant deficiency of . . . is interpreted as a chance finding". It is not chance, it is bad statistics. Looking through back numbers of the *Journal,* you may note that the chi-squared test is perhaps the most often abused technique in use. I am constantly surprised that the *Journal* referees should fail to identify such a classical and elementary error.

A third point concerns the way in which the authors interpret the findings. They conclude that "this study does not demonstrate any curative effect" and then go on to discuss the possible reasons why this might be so. But who says there has been no cure? The doctor? The patient? No, it appears to be the questionnaire which is being used to measure levels of psychoneurosis. It is vital that studies which measure success or failure, or any other sort of outcome, by means of a questionnaire should recognize the difference between what an artificial questionnaire says is going on and what actually is happening, especially in such a complicated field as psychosocial disorder. To examine the authors' conclusion in this light it is possible for them to say only that their study did not show any beneficial effect in terms of the questionnaire score. Anything else is beyond the scope of such a small study.

Of course, it is possible that the questionnaire has been well validated and is known to correlate very well indeed with the outcome being evaluated. In this case it might be argued that such a conclusion might be justified. The problem here is that it is virtually impossible to be certain that the conditions in which the questionnaire was validated originally were the same as those holding for the current research. Even with a well validated questionnaire the research worker must use supreme caution in interpreting the results.

This brings me to my fourth and final point. The Middlesex Hospital Questionnaire, the questionnaire used by Dr Harris and his colleagues, cannot yet be called a validated instrument. In a study of its use in 545 men it was suggested that it was not a suitable questionnaire for psychiatric screening. The same study found so many elementary design faults in it which would bias the measurements it made that it concluded that until the questionnaire was completely redesigned and re-evaluated in its corrected form it would be impossible to interpret any measurements produced by its use (Williamson *et al.*, 1976).

There remains so much to be done in the field of general practice that it seems to me to be important that we recognize priorities in our future research efforts. It seems equally essential to ensure that research, when it is carried out, is worthy both of publication and of a readership. The *Journal* can make a stand over these matters which could only be applauded and I hope that this letter will take us in that direction.

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Reference

Williamson, J. D., Robinson, D. & Rowson, S. C. (1976). *International Journal of Social Psychiatry,* **22/3**, 167-188.

THE INDEPENDENT CONTRACTOR AND THE PRIMARY CARE TEAM

Sir,

The draft evidence submitted by the College to the Royal Commission on the NHS (distributed with the December *Journal*) is notable for its support of two principles governing the provision of primary care within the NHS in Britain today. Item ten asserts: "Primary health care should be provided normally by functionally integrated teams of general practitioners, nurses, health visitors, and where appropriate, social workers, supported by receptionists and secretarial staff." Item 13 states: "General practitioners should remain independent contractors so that patients have an independent medical adviser in a state dominated health service."

As far as I know, no one has drawn attention to the inherent antithesis in maintaining these two positions at the same time. At present some nurses in the primary care teams are employed directly by general practitioners. Others, together with all of the health visitors and midwives in the primary care team, are employed by the area health authority, which both appoints and withdraws them from the team, setting limits to their freedom and range of activity within the team. The general practitioner is the only member of the team with the status of an independent contractor.

For some time it has been apparent that this fundamental difference in status is inimical to the "functional integration" of the team that the College rightly believes to be essential to the development of primary care.

There are two ways in which the antithesis could be resolved. On the one hand, general practitioners could be made salaried servants of the area health authority, so losing their independent status and being brought into line with the nurses, midwives, and health visitors. There are many individuals and organizations who support this view, and some of them are very influential. For example, the Society of Secretaries of Welsh Community Health Councils have submitted evidence in favour of this solution to the Royal Commission on the NHS.

There is, however, an alternative approach, one that has not been put forward before, but which nevertheless has everything to commend it. Why not extend independent contractor status to all nurses, midwives, and health visitors who are members of primary care teams? Why should they not be admitted to group practice partnerships? The group practice and the primary team would then become identical, and the members of the practice team, all partners, would select newcomers to the team themselves. The team would then indeed be "functionally integrated". Nurses, midwives, and health visitors would be encouraged to put down roots and stay within the team as do the general practitioners, instead of remaining birds of passage as they so often are today.

The divided loyalties which so often impose great strains on primary care teams would disappear overnight. All members of the team would be true partners, all holding stakes in the enterprise, though not, of course, drawing equal shares. The team could then develop its programme of care far more efficiently than at present.

In our modern society members of the service industries, such as plumbers, electricians, and builders are often independent contractors. Why not members of the caring professions? All the arguments in favour of an independent contractor status for general practitioners apply equally to other

professionals working in primary care.

If we really wish to pay more than lip service to the functional integration of members of the primary care team, this is the direction in which our thoughts should be moving today.

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PARALDEHYDE AND STATUS EPILEPTICUS

Sir,

"Does any general practitioner really use paraldehyde these days?", asks P. J. Hoyte in his recent book review (January *Journal*, p. 59).

This is not the first time that I have seen the use of paraldehyde in general practice disparaged recently, and I for one am immensely reassured by the glass syringe and the non-expired ampoules of paraldehyde I keep in my bag—even though seldom used.

Are we really to suppose that intravenous diazepam ('Valium') can always be injected into the veins of a fitting child or an obese woman, particularly in general practice, where good illumination and a strong helper may not be available, and when the disadvantages of a short-acting drug may become all too apparent in the ambulance?

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SIGMOIDOSCOPY IN GENERAL PRACTICE

Sir,

Last year (April *Journal*) I was taken to task for recommending the use of a sigmoidoscope as a diagnostic instrument in general practice. I therefore thought it might be useful to review the patients who were sigmoidoscoped in this practice in 1976, and then readers can draw their own conclusions.

The practice comprises five partners of whom four use the sigmoidoscope. The total practice population is about 12,500. In 1976 41 sigmoidoscopies were performed; 23 of these were done before requesting a barium enema because the local x-ray department will not accept people for barium enema until they have been sigmoidoscoped. It is not surprising, therefore, that in 29 cases the examination was negative.

There were 12 positive findings consisting of five cases of non-specific proctitis (which included some follow-up examinations) and two cases of patchy erythematous changes, which were possibly due to early proctitis. Haemorrhoids were confirmed as a cause of rectal bleeding in three cases, and there was a case each of a rectal polyp and a villous adenoma.

Twenty-three cases were referred for barium enema, of which 13 were found to be normal and ten were abnormal; there were seven cases of diverticular disease and one case of carcinoma of the sigmoid colon. One case showed x-ray evidence of proctitis and in another a filling defect was diagnosed and referred but later found to be normal.

About half way through the year we acquired some biopsy forceps and a biopsy was taken in ten cases. Five were reported as normal and three confirmed the presence of proctitis. One polyp and one villous adenoma were reported.

It will, of course, be argued that 41 sigmoidoscopies among four partners does not give each doctor enough practice to enable him to give a reliable opinion, but in our experience this is not the case. Once the technique of doing the examination has been mastered, the likelihood of any significant pathology being overlooked is very small.

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Reference

Evans, J. W. (1976). *Journal of the Royal College of General Practitioners*, **26**, 261.

CONTRACEPTIVE RECORD CARD

Sir,

I would agree with Dr Froggatt (February *Journal*, p. 107) that the use of a planned contraceptive record card aids the collection of significant positive and negative data, and provides an *aide-mémoire* to ensure that important points of history are not omitted. I have been using a prototype card for the past 18 months which was printed for us by a drug firm (Wyeth Laboratories) and am aware of at least three derivatives of this which are available on request from this and other firms supplying contraceptive pills.

However, with space at a premium, I feel that Dr Froggatt's card could be modified to give greater prominence to the most relevant information and provide more space for comment. I doubt whether such full details of obstetric history (taking up a third of a side) are relevant; I have found that more space needs to be devoted to contraceptive history, which can often be complicated, for example by reasons for failure to continue previous methods. No specific space is provided to note the presence or absence of history of pelvic inflammatory disease, which deserves consideration in assessing suitability for an IUCD. It also appears that details of personal and family history are combined under one heading; it would be easier if these were separated.

I hope that the College will be able to produce a standard record card for contraceptive services. The information contained in the medical record envelopes of patients who have previously been provided with an oral contraceptive often amounts to no more than a blood pressure reading. Any aid to improving this situation would surely be welcome.

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Sir,

In the February issue (p. 107-109) I was most interested to see an article on contraceptive records in general practice.

The author did ask for constructive criticism and I note that there is no space on the card to enter the fact that a claim has been submitted for either contraceptive services or a cervical smear. I think it should therefore be redesigned with this in mind.

I am of the opinion that good practice should benefit the doctor as well as the patient, and I feel that without good record-keeping money is likely to be lost by default.

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DOCTOR/PATIENT RELATIONSHIP

Sir:

I presume that your correspondent, Dr D. M. Smith, in his letter in the January *Journal* (p. 58) means to be taken seriously, and he cannot therefore object to a systematic rebuttal of his arguments. They are in any case but a series of *non sequiturs*.

With great respect, his apologia is a prime example of woolly thinking combined with a hopelessly impractical approach to common problems. Such attitudes bid fair to be some of the main